TOWN OF CORNWALL KINDERKAMP
REGISTRATION FORM SESSION 1_____2_____

CHILD'S NAME: _____ DATE OF BIRTH: _____ AGE: _____
FIRST MI LAST

ADDRESS: _____
STREET TOWN ZIP

TELEPHONE #: _____

HEIGHT: _____ WEIGHT: _____ EYE COLOR: _____ HAIR COLOR: _____

ANY DISTINGUISHING MARKS/CHARACTERISTICS: _____

PARENT/GUARDIAN NAME: _____ #: _____
DAYTIME TELEPHONE

E-MAIL ADDRESS _____

PARENT/GUARDIAN WILL BE CALLED FIRST IN AN EMERGENCY. IF YOU CANNOT BE REACHED PLEASE NAME ANOTHER PERSON TO CONTACT::
NAME: _____ RELATION TO CHILD: _____

DAYTIME TELEPHONE # _____

CHILD'S MEDICAL HISTORY: PLEASE CHECK ONE OF THE FOLLOWING:

_____MY CHILD HAS NO KNOWN MEDICAL CONDITION THAT THE CAMP DIRECTOR AND CAMP MEDICAL STAFF SHOULD BE ADVISED OF.

_____MY CHILD HAS ONE OR MORE MEDICAL CONDITIONS THAT THE CAMP STAFF SHOULD BE ADVISED OF. ***PLEASE FILL OUT THE NEXT SECTION***
MY CHILD HAS THE FOLLOWING ALLERGIES: _____

MEDICAL CONDITIONS: (EX: ASTHMA) _____

ANY SURGERY/PROCEDURE STILL REQUIRING DOCTOR SUPERVISION: _____

IF YOU ARE ADVISING THE CAMP STAFF OF ANY MEDICAL INFORMATION PLEASE PROVIDE THE FOLLOWING INFORMATION:
DOCTOR'S NAME: _____ PHONE NUMBER: _____
ADDRESS: _____

_____ _____
DATE SIGNATURE OF PARENT/GUARDIAN

CAMP T-SHIRT SIZES: CIRCLE ONE
CHILD SIZES: SMALL MEDIUM LARGE